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In The

Supreme Court of the United States

DON STENBERG, ATTORNEY GENERAL OF THE STATE OF NEBRASKA, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF AMICI CURIAE of Association of American Physicians and Surgeons, Illinois State Medical Society, Physicians' Ad hoc Coalition for Truth, Christian Medical and Dental Society, Catholic Medical Association, Physicians Resource Council of Focus on the Family, Pennsylvania Physicians Resource Council, Physicians Research Council of the Indiana Family Institute, New Jersey Physicians Resource Council, Oklahoma Physicians Resource Council, Texas Physicians Resource Council, Wisconsin Physicians Resource Council, Drs. Kathi A. Aultman, Gerard Black, Watson A. Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Peter R. DeMarco, Fred de Miranda, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Joseph R. McCaslin, Phillip McNeeley, Phillip Metz, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, Dennis D. Weisenburger, and Joseph R. Zanga, IN SUPPORT OF PETITIONERS

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BRIEF AMICI CURIAE IN SUPPORT OF PETITIONERS

This *amici curiae* brief is respectfully submitted on behalf of the Association of American Physicians and Surgeons, Illinois State Medical Society, Physicians' Ad hoc Coalition for Truth, Christian Medical and Dental Society, Catholic Medical Association, Physicians Resource Council of Focus on the Family, Pennsylvania Physicians Resource Council, Physicians Research Council of the Indiana Family Institute, New Jersey Physicians Resource Council, Oklahoma Physicians Resource Council, Texas Physicians Resource Council, Wisconsin Physicians Resource Council, Drs. Gerard Black, Watson Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Phillip McNeeley, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, and Joseph R. Zanga, MD, in support of Petitioners and in favor of reversal of the judgment of the United States Court of Appeals for the Eighth Circuit entered on September 24, 1999.[1]

INTEREST OF THE AMICI CURIAE

Amicus Curiae The Association of American Physicians & Surgeons, Inc. ("AAPS") is a nonprofit organization dedicated to defending the practice of private medicine. Founded in 1943, AAPS has thousands of members nationwide in all specialties. AAPS frequently participates in litigation in defense of the practice of medicine in accordance with the Oath of Hippocrates. Central to

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[1] Pursuant to Rule 37.3 of the Rules of this Court, *Amici* have obtained and file herewith the written consent of each of the parties to the filing of this brief. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the Amici Curiae, its members, or its counsel made monetary contribution to the preparation and submission of this brief.

the interest of AAPS are procedures which, like the one at issue here, are not designed to promote and protect the health of the patient.

Amicus Curiae Illinois State Medical Society ("ISMS") is a nonprofit professional organization with membership of over 16,000 licensed physicians, medical residents and medical students. ISMS policy specifically states:

> ISMS opposes all intact dilation and extraction procedures (Partial-Birth Abortion). (1997 Annual meeting)

ISMS participation is limited to the purposes of this Brief to establish the medical realities surrounding intact dilation and extraction and not the penalties provided in the Nebraska statute.

Amicus Curiae The Physicians' Ad Hoc Coalition for Truth is an organization of more than 600 physicians from around the nation – most specializing in the fields of obstetrics and gynecology, perinatology or pediatrics – that have united to effectively express their opinion that the procedure known as partial-birth abortion is never medically necessary, and often may be contraindicated. This organization takes no position on the ultimate question of whether the current legal protections of abortion should be continued.

Amicus Curiae The Christian Medical & Dental Society (CMDS) was founded in 1941 and today represents over 14,000 members – primarily practicing physicians representing the entire range of medical specialties. This organization views principles of biblical faith as essential to protecting the lives and best interests of patients, the conscientious practice of medicine according to long-standing Hippocratic and religious principles, and to preserving the public respect accorded to physicians as guardians of health and life.

Amicus Curiae Catholic Medical Association ("CMA") is an association of physicians who seek to integrate their understanding of the teachings of the Roman Catholic Church into their professional lives. CMA believes that partial-birth abortion is never medically necessary.

Amicus Curiae Pennsylvania Physicians Resource Council ("PPFC") is an association of physicians concerned for the health and well-being of women and preborn children. PPFC has 250 members and concurs that intact D & X is not recognized as the preferred medical treatment at any stage of pregnancy, nor for any particular condition experienced in pregnancy.

Amicus Curiae Indiana Physicians Research Council ("IPRC") is an association of physicians and part of the Indiana Family Institute. IPRC was instrumental in the passage of a partial birth abortion ban that was enacted by the Indiana General Assembly in 1997.

Amicus Curiae Texas Physicians Resource Council ("TPRC") is a subsidiary of Free Market Foundation of Texas. TPRC represents approximately 500 physicians. TPRC recognizes that the United States Supreme Court's decision in this case will impact medical practice in Texas and endorses the ban on partial birth abortion.

Amicus Curiae New Jersey Physicians Resource Council ("NJPRC") is an association of 45 New Jersey physicians which provides insight on medical, ethical and social issues for policymakers, medical professionals and the public. NJPRC does not believe that partial birth abortion is ever medically indicated to save the life of the mother or to protect her future fertility.

Amicus Curiae Oklahoma Physicians Resource Council ("OPRC") is a multi-specialty organization of Oklahoma physicians. OPRC is associated with Oklahoma Family Policy Council, a nonprofit research and educational organization. OPRC and the physicians associated with it believe that bans against the medical performance of partial-birth abortion procedures are legitimate, moral and ethical public policy positions for states to hold.

Amicus Curiae Physicians Resource Council ("PRC") of Focus on the Family, a California non-profit religious corporation, is an advisory organization that helps identify critical, medically related issues and to form national task forces to develop and implement strategies and objectives to preserve traditional family values. The PRC

is comprised of 22 physicians and oversees the publication of *Physician Magazine* which is received by approximately 74,000 physicians.

Amicus Curiae Wisconsin Physicians Resource Council (WPRC) operates in concert with The Family Research Institute of Wisconsin, Inc. (FRI), which is a charitable and educational organization. The partial-birth abortion issue in this case will impact medical practice in Wisconsin since Wisconsin passed a similar ban in 1998.

Amici curiae Gerard Black, Watson Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Phillip McNeeley, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, and Joseph R. Zanga, are physicians, many of whom have testified before Congress or their state legislatures regarding the medical necessity of the procedure known as "partial-birth abortion."

SUMMARY OF ARGUMENT

Amici offer this brief for the limited purpose of establishing the medical realities surrounding the procedure known as "partial birth abortion," "intact dilation and extraction," or "intact dilation and evacuation." *Amici* believe it is both desirable and constitutional to restrict the use of this procedure as Nebraska has done in this case. On this issue *amici* echo the sentiments expressed by a representative of the American Medical Association ("AMA"):

> This issue is whether the partial delivery of a living fetus for the purpose of killing it outside of the womb ought to be severely restricted. We believe, as a matter of ethical principle, it should rarely *if ever* be done. And although we also believe physicians should have broad discretion in medical matters, both this procedure and

> assisted suicide (as well as female genital mutilation and lobotomies) can and should be regulated if the profession won't do it.

Letter to the New York Times, dated May 30, 1997 by P. John Seward, M.D. in his capacity as AMA Executive Vice President (emphasis added).[2]

As a legitimate health regulation the Nebraska statute succeeds in limiting the use of an unproven and ethically questionable practice, while insuring that safe and effective procedures remain available for women seeking to obtain abortions. While the autonomy of the medical profession is an important and valuable component of the success American medicine has experienced in the attempt to provide the highest quality of care in the world, this interest does not require the profession or the state to disregard practices that erode the public's understanding of and confidence in the physician's role in assisting pregnant women. Dilation and extraction is such a practice, and thus should be prohibited.

ARGUMENT

I. D&X IS GENERALLY RECOGNIZED AS A DISTINCTIVE TECHNIQUE

A. THE FINDINGS OF THE DISTRICT COURT BELOW INDICATE THAT DILATION AND EXTRACTION IS A DISTINCTIVE TECHNIQUE CLEARLY DISTINGUISHABLE FROM DILATION AND EVACUATION AND OTHER ABORTION TECHNIQUES

The legal theories and factual findings by which the district court invalidated Nebraska's Partial-Birth Abortion Prohibitions are in tension with one another. On the one hand, the claim is made that the prohibitions are vague or constitute an undue burden because they

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[2] Reproduced at App. 7-9 for the convenience of the Court.

encompass not only intact dilation and extraction ("D&X"),[3] but also dilation and evacuation ("D&E") abortion, the latter method being the most common method of second trimester abortion.[4] In accordance with this legal theory, the district court attempted to blur the line between D&X and other methods.[5]

On the other hand, the claim is made that D&X is a distinctive method with health benefits for women beyond that of other methods, including D&E.[6] For this purpose, of course, the district court drew a sharp distinction between D&X and other methods, in order to make comparative claims or findings about the supposed medical superiority of D&X over D&E and other methods.[7]

Obviously, when the district court finds that the D&X procedure is medically superior to other methods, it is implicitly acknowledging that D&X is a distinctive technique, clearly distinguishable from, for example, D&E abortion. Other sections of this brief will take issue with

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[3] This is the term applied to the procedure by its originator when it was first formally discussed among abortion providers. *See* Martin Haskell, *Dilation and Extraction for Late Second Trimester Abortion* (presented at the National Abortion Federation Risk Management Seminar, Sept. 13, 1992), published in *The Partial-Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Senate Comm. On the Judiciary*, 104th Cong., 1st Sess. 3 (Nov. 17, 1995).

[4] *See, e.g., Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1127-32 (D. Neb. 1998); 192 F.3d 1142, 49-50 (8th Cir. 1999).

[5] *See, e.g., Carhart v. Stenberg*, 972 F. Supp. 507, 525 (D.Neb. 1997) (D&X is a variant of D&E and the difference between the two procedures is not a medical issue, but merely political). 11 F. Supp. 2d at 1106 (claiming that Carhart "intends to remove fetus intact" for all post-fifteen week abortions, although only successful in five to ten percent of such abortions).

[6] *See, e.g., Carhart*, 972 F. Supp. at 525-27; 11 F. Supp. 2d at 1122-23.

[7] *See id.*

the district court findings on the supposed benefits of D&X, and will demonstrate that the statutory definition of "partial-birth abortion" sufficiently distinguishes intact D&X from standard D&E. At the outset, however, it should be recognized that the district court findings themselves presuppose that the D&X procedure is indeed a distinctive method, clearly distinguishable from D&E abortion and other methods.

B. MEDICAL SOURCES INDICATE THAT INTACT D&X IS A DISTINCT TECHNIQUE

The term "D&X" abortion appears to have been introduced by Dr. Martin Haskell in a paper presented at a 1992 National Abortion Federation Conference.[8] The district court below specifically described the "Haskell D&X" as follows:

> On the first and second days of the procedure, Dr. Haskell inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are ruptured. Then, with the guidance of ultra-sound, Haskell inserts forceps into the uterus, grasps a lower extremity, and pulls it into the vagina. With his fingers, Haskell then delivers the other lower extremity, the torso, shoulders, and the upper extremities. The skull, which is too big to be delivered, lodges in the internal cervical os. Haskell uses his fingers to push the anterior cervical lip out of the way, then presses a pair of scissors against the base of the fetal skull. He then forces the scissors into the base of the skull, spreads them to enlarge the opening, removes the scissors, inserts a suction catheter, and evacuates the skull contents. With the head decompressed, he then removes the fetus completely from the patient.

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[8] *See* Haskell, *supra*.

972 F. Supp. at 516 (quoting *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051 (S.D. Ohio 1995)).

Dr. Haskell's 1992 paper explains the distinction between D&X and other methods as follows:

> The surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus. Nor are inductions or infusions used to expel the intact fetus.
>
> Rather, the surgeon grasps and removes a nearly intact fetus through an adequately dilated cervix. The author has coined the term *Dilation and Extraction* or *D&X* to distinguish it from dismemberment-type D&E's.
>
> . . . .
>
> Classic D&E is accomplished by dismembering the fetus inside the uterus with instruments and removing the pieces through an adequately dilated cervix.[9]

As the district court found, Dr. Haskell employed his new method for pregnancies that had progressed to twenty weeks or beyond.[10] Dr. Haskell's 1992 paper explained that classic D&E dismemberment became difficult beginning at twenty weeks due to "the toughness of fetal tissues at this stage of development." Alternative D&E methods involved causing fetal death by various methods prior to surgery, to produce softening of fetal tissues. Late second trimester abortions could also be performed by induction methods. Dr. Haskell's D&X method was a new procedure that resolved the problem of fetal tissue toughness post-twenty weeks by providing a non-induction, non-dismemberment technique.[11] Instead of either dismembering the fetus piece by piece

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[9] *See* Haskell, *supra*.

[10] 972 F. Supp. at 516.

[11] *See id.*

through the cervix or inducing labor, Dr. Haskell provided extensive dilation in a three-day procedure, then delivered all but the head of the fetus into the vagina, followed by reduction of the head size through evacuation of the skull contents, allowing complete delivery of the fetus.

There has been a certain amount of confusion over the correct term for this distinctive procedure. At the time that Dr. Haskell presented his paper there were no references to this procedure in any medical textbooks, dictionaries, or journals. Even standard texts on abortion, such as Warren Hern, *Abortion Practice* (1990 reprint), did not name or describe the procedure. Dr. Haskell claimed to have "coined the term Dilation and Extraction or D&X".[12] However, another physician employing the method, Dr. James T. McMahon, chose the slightly different name "intact dilation and evacuation (intact D&E)."[13] Subsequently, abortion rights proponents such as the National Abortion Federation and Planned Parenthood divided over the right terminology, the former adopting Haskell's terminology,[14] the latter McMahon's.[15] Both organizations claimed their term the proper "medical" one, in supposed contrast to the term "partial-birth abortion," which was derided by advocates of the procedure as a non-medical term.[16] In the absence of any published descriptions of

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[12] Haskell, *supra*.

[13] *See* James Bopp & Curtis R. Cook, *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues L. & Med. 3, 20 (1998).

[14] Planned Parenthood Federation of America, *Fact Sheet: Why Abortion Bans are Unconstitutional* (visited February 22, 2000) <http://www.plannedparenthood.org/library/ABORTION/abortban__fact.html.>

[15] National Abortion Federation, *NAF's Response to "Partial-Birth Abortion" Ban* (visited February 22, 2000) <http://www.prochoice.org/issues/ban.htm.>

[16] *See id.*

the term in medical textbooks, dictionaries, or standard medical journals, and amidst political controversy over proposed bans on partial-birth abortion which were aimed at prohibiting the new Haskell/McMahon procedure, it was difficult to standardize precise medical terminology for the new procedure.

Subsequently the American College of Obstetricians and Gynecologists ("ACOG") issued a January 1997 statement adopting a hybrid term "intact dilation and extraction" or "intact D&X," combining the Haskell/McMahon definitions. The American Medical Association relied upon this report in issuing its own policy declarations. Therefore, the term "intact dilation and extraction" or "intact D&X" – which is sometimes shortened simply to "D&X" – appears to have become the most common appellations for the procedure in question.[17]

ACOG states that intact D&X has been described as including the following four elements:

> (1) the deliberate dilation of the cervix, usually over a sequence of days;
>
> (2) instrumental conversion of the fetus to a footling breech;
>
> (3) breech extraction of the body, excepting the head; and
>
> (4) partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

11 F. Supp. 2d at 1105.

The ACOG acceptance of this description indicates once again that D&X is medically understood as a distinctive technique, different from classic D&E abortion, even if it is sometimes denominated as a variant form of D&E. This four-part description is useful so long as it is not

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[17] *See* 11 F. Supp. 2d at 1105 & n.10. Amici do not suggest that unanimity has emerged on the proper name of this procedure, even at this time.

taken too literally. For example, dilation is "usually over a sequence of days" post twenty weeks, but prior to twenty weeks instrumental dilation not requiring this extended time frame may be employed.[18] (This is significant to the present case, as the Respondent Dr. Carhart testified that he only performed D&X from 16 to 20 weeks.)[19] Secondly, as Dr. Frank Boehm, professor of obstetrics and gynecology at the Vanderbilt University School of Medicine and Director of Obstetrics for the hospital, noted in testimony before the district court, version (or purposeful manipulation) is only needed when the fetus does not present in breech.[20] In the present case Dr. Carhart testified that he only chose to perform a D &X when the fetus presented in breech or where repositioning the fetus from a side presentation resulted in a breech presentation.[21]

The medical literature on D&X, although severely limited, takes into account these slight variations in technique. For example, in an article based on the AMA Board of Trustees 1997 Report, which was approved by the AMA House of Delegates in June 1997, the authors quote the ACOG description of intact D&X, then note "However, there may be variations of D&X that depart from this protocol, such as when an identical procedure is

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[18] "For procedures at up to 16 weeks' gestation, placing the dilators 4-8 hours prior to surgery may suffice. Beyond 16 weeks it is common practice to allow overnight dilation, and some mid to late second trimester protocols call for a second insertion in 16-24 hours." W. Martin Haskell *et al.*, *Surgical Abortion After the First Trimester* in *A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.*, 1999) at 128.

[19] 972 F. Supp. 507 at 514-15.

[20] Ex. 32, Videotaped Dep. of Dr. Boehm at 31:23-32:6. This point was first noted by Dr. Haskell in his 1992 paper presented at the National Abortion Federation Fall Risk Management Seminar. See Haskell, *Dilation and Extraction*, *supra* ("Version (as needed)").

[21] 972 F. Supp. at 522 n.20.

performed without converting the fetus to a footling breech or using decompression without suction evacuation of the cranial contents."[22]

The Nebraska statute takes account of these variations, and other variations which at this point are not seriously proposed by any medical professional (e.g., intentionally delivering a live fetus head-first in order to kill it before completed delivery). A more detailed medical definition could invite practitioners to evade the law by modifying other minor details of the procedure. What remains the same throughout these variations and distinguishes the D&X procedure from other abortion techniques is: (1) Deliberate dilation of the cervix, technique and duration variable depending on stage of pregnancy and other factors; (2) Instrumental or manual conversion of the fetus to a footling breech where necessary; (3) Breech extraction of the body except the head; and (4) Reduction of the head size of a living fetus through methods such as decompression or evacuation of the intracranial contents to effect vaginal delivery of a dead, but otherwise intact, fetus.

II. INTACT D&X IS NOT RECOGNIZED WITHIN THE MEDICAL PROFESSION AS THE PRIMARY INDICATED TECHNIQUE OR STANDARD OF CARE AT ANY STAGE OF PREGNANCY OR FOR ANY PREGNANCY, AND THEREFORE CANNOT BE CONSIDERED MEDICALLY SUPERIOR TO THE STANDARD METHODS OF SECOND TRIMESTER ABORTION, SUCH AS D&E.

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[22] Janet E. Gans Epner, *et al.*, *Late-Term Abortion*, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998). See also W. Martin Haskell, *et al.*, *Surgical Abortion After the First Trimester* 136-7 in *A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.* eds., 1999) (discussing variations in procedure for breech and vertex position).

A. THE DISTRICT COURT ISSUED CONTRADICTORY FINDINGS OF FACT REGARDING THE SUPPOSED SUPERIORITY OF INTACT D&X WHICH MUST BE REGARDED AS CLEARLY ERRONEOUS

The district court correctly found, and the court of appeals agreed, that standard D&E abortion is the most common abortion method during the relevant gestational period.[23] This finding is supported by the practice of Respondent Dr. Carhart, who was found to perform standard D&E abortion rather than intact D&X in approximately ninety percent of his post-fifteen week abortions.[24] Although Dr. Haskell designed the D&X originally for the post-twenty-week period, the district court found that Respondent Dr. Carhart chose *not* to perform a D&X post-twenty weeks, but instead "induces fetal death by injection."[25] During the period from sixteen to twenty weeks Dr. Carhart only performs the D&X procedure when he finds the fetus in breech (or sometimes transverse, or side) presentation. Thus he employs D&X in approximately ten to twenty abortions out of the 190 sixteen-to-twenty-week abortions he performs annually.[26] The district court also recorded Dr. Carhart's procedure if he found the fetus presenting in transverse (sideways) position:

> Carhart grasps whatever portion of the fetus he can in order to turn it so that part of the body will pass through the cervix. He performs this procedure because "you can't bring the fetus out sideways." If he can grasp the fetus "feet first"

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[23] 11 F. Supp. 2d at 1127-30; 192 F.2d at 1149-51 (D&E most common abortion method for second trimester abortions).

[24] *See* 972 F. Supp. at 520-22.

[25] See 972 F. Supp. at 522.

[26] 972 F. Supp. at 511, 520, 521 & n.20.

> he will, but Carhart does not "intentionally spend a lot of time doing that."

972 F. Supp. at 521 n.20 (quoting portions of Dr. Carhart's testimony).

Finally, the district court found that Dr. Carhart was, so far as he knew, the only provider of post-sixteen-week abortions in Nebraska, and therefore the only physician in the state who performed the D&X procedure.[27]

The district court in summary found: (1) Standard D&E abortion is the most common method used during the relevant gestational period; (2) Respondent, the only provider of abortions during the relevant gestational period, chooses D&E over D&X approximately ninety percent of the time; and (3) Respondent allowed the presentation of the fetus during the period from sixteen to twenty weeks to determine which method he employed, and cared so little which technique he used that, when faced with a transverse lie, he did not "intentionally" spend "a lot of time" seeking to grasp the feet so that he could perform a D&X rather than D&E.

Directly contradictory to these findings, the district court also found that "medical evidence established that the D&X procedure is appreciably safer for women than the D&E procedure."[28] The district court relied on claims that D&X was superior to D&E because of (1) less chance of trauma to the cervix and uterus from bony fragments; (2) less instrumentation in the uterus, lessening the risk of complications from tearing or perforating the uterus; (3) prevention of disseminated intravascular coagulopathy and amniotic fluid embolus; (4) reduced chance of retained fetal parts; (5) reduced risk of free floating head; and (6) shorter operating time, reducing the amount of bleeding and the risks of hemorrhage and infection.[29] The only evidence offered to support the existence of these

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[27] 972 F. Supp. at 511.

[28] 972 F. Supp. at 525.

[29] *See id.* at 526-27.

benefits was the testimony of the Respondent and the speculation of experts. The record is void of any controlled study or article from a peer-reviewed journal establishing that the D&X procedure is superior in any way to the D&E procedure most commonly employed in second and third trimester abortions.[30]

All the reasons given by the district court for finding intact D&X "appreciably safer for women" than D&E, if valid, would apply to the ninety percent of abortions for which Respondent Carhart chose *not* to perform a D&X. Moreover, the district court opinions fail to list any potential negative effects of the D&X procedure. Therefore, the findings of the district court suggest that Respondent Carhart, and indeed the vast majority of

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[30] The only generally available medical publication to make similar claims on behalf of the procedure is a recently published medical text, *A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.* eds.) (1999). Based exclusively upon the self-reporting of the deceased Dr. James T. McMahon, one of the originators of the D&X procedure, the text states "This major complication rate is virtually identical to that of an earlier series of nonintact D&E's reported by Hern (3.07 [per] 1000 cases) despite the fact that nearly one-fourth of the cases in McMahon's series exceeded Hern's 25-week gestational limit." W. Martin Haskell, *et al.*, *Surgical Abortion After the First Trimester*, in *A Clinician's Guide to Medical and Surgical Abortion*, *supra* at 137. This information was available at the time of trial, yet in the absence of any external review or indicia of reliability, none of the Respondent's experts or the district judge considered it relevant. Even taken at face value this statement provides little support for the finding of the district court that D&X is superior to D&E.

The chapter goes on to assert "Haskell [the other originator of D&X and co-author of the chapter] has performed more than 1500 intact D&E's at 20-26 weeks' gestation without a serious event." *Id.* No information is provided regarding the methodology of follow-up to obtain information about delayed complications, nor is there an adequate explanation of Haskell's or McMahon's definition of what constitutes a complication.

second-trimester abortion providers, are guilty of deliberately failing to choose an "appreciably safer" method of abortion, D&X.

The district court findings are self-contradictory. They simultaneously condemn the State of Nebraska for allegedly making illegal the most common form of second trimester abortion (D&E), while also claiming that this same method is, as measured against D&X, so medically deficient as to constitute a serious health risk for women.

The district court findings on the safety of D&X, in short, cannot be taken seriously as "findings of fact," but instead should be read merely as alternative legal theories. Alternative legal theories or alternative rationales, even where offered by a district court, cannot however, be accorded the same weight as findings of fact. Surely a single district judge lacks the authority to condemn as medically deficient and unsafe a procedure – D&E abortion – which is clearly within the current standard of care for second trimester abortion.[31]

Ironically, the district court condemned as "irrelevant" "political rhetoric" prior statements issued by the AMA supporting the proposed Partial-Birth Abortion Ban Act of 1997, H.R. 1122.[32] To disregard the predominant practice of substantially all physicians, including the Respondent, and condemn the statements of the largest organized group of physicians in the country as merely "political" fuels the public perception in some quarters that abortion jurisprudence is driven by the personal or political preferences of the judiciary, rather than reasoned

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[31] Paul D. Blumenthal, *et al.*, *Abortion by Labor Induction*, in *A Clinician's Guide to Medical and Surgical Abortion*, *supra* at 139 ("Compared to induction abortion, dilation and evacuation (D&E) has generally been recognized as the safest and most expeditious means of pregnancy termination for similar gestational ages, specially prior to 20 weeks").

[32] 972 F. Supp. at 525 n.27.

interpretation of medical facts and constitutional limitations. In light of the common practice of all physicians testifying in this case, and the statements of the larger medical community that no circumstances necessitate the use of intact D&X, the findings of the district court on the supposed medical superiority of intact D&X abortion must be set aside as clearly erroneous.

B. MEDICAL SOURCES INDICATE THAT INTACT D&X IS NOT THE STANDARD OF CARE OR PREFERRED METHOD AT ANY STAGE OF PREGNANCY OR FOR ANY PREGNANCY, AND MAY HAVE SIGNIFICANT MATERNAL HEALTH RISKS THAT WERE NOT CONSIDERED BY THE DISTRICT COURT

The varied statements by ACOG and the AMA reflect professional organizations caught between two impulses. On the one hand, it is clear, as reflected for example by *amici*, that there are significant numbers of physicians and health care providers who hold that intact D&X is both medically and ethically objectionable.[33] Further, D&X is not the standard of care or preferred

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[33] " 'I have very serious reservations about this procedure,' " said Colorado physician Warren Hern, M.D. The author of *Abortion Practice*, the nation's most widely used textbook on abortion standards and procedures, Dr. Hern specializes in late-term procedures . . . of the procedure in question he says, " 'You really can't defend it.' " Diane M. Gainelli, *Outlawing abortion method: Veto-proof majority in House votes to prohibit late-term procedure*," 38 Amer. Med. News 1 (Nov. 20, 1995) (reproduced at App. 11-20 for the convenience of the Court); M. LeRoy Sprang & Mark G. Neerhof, *Rationale for Banning Abortions Late in Pregnancy*, 280 J. Amer. Med. Ass'n 744 (Aug. 26, 1998); and Janet E. Gans Epner, *et al.*, *Late-term Abortion*, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998) ("[i]n the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown").

method at any stage of pregnancy or for any pregnancy, according to current medical literature and standards. On the other hand, professional organizations such as ACOG and the AMA have an understandable tendency to resist governmental regulation of medical procedures and medical providers, particularly when regulation may involve criminal sanctions.

These conflicting impulses are well illustrated by the ACOG and AMA literature pertaining to intact D&X/ partial-birth abortion. A January 1997 ACOG statement, after describing the intact D&X procedure, stated:

> A select panel convened by the ACOG could identify no circumstances under which this procedure [intact D&X] . . . would be the only option to save the life or preserve the health of the woman. An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision.

See 11 F. Supp. 2d at 1105 n.10.

The first sentence of the ACOG statement reflects the failure of medical experts to identify any stage of pregnancy or particular circumstance in which intact D&X abortion represents the standard of care, or would be medically necessary to protect the life or health of women. In direct opposition to the clearly erroneous finding of the district court that intact D&X was generally and appreciably safer than the predominant D&E, the ACOG's panel of experts could not identify a *single circumstance* where D&X is medically superior. A subsequent policy statement by the AMA agreed, finding that "there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion." AMA Policy H-5.982, *quoted in Hope Clinic v. Ryan*, 195 F.3d 857, 872 (7th Cir. 1999) (en banc).

These expert findings of ACOG and the AMA were employed by the AMA when it issued statements in support of the Partial-Birth Abortion Ban of 1997, which is quite similar to the Nebraska law at issue herein. The AMA Board of Trustees Press Release and Fact Sheet took the position that the federal bill did *not* prohibit D&E, but only prohibited intact D&X. The AMA press release described that procedure as "broadly disfavored – both by experts and the public. . . . It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development."[34] The AMA Board of Trustees Fact Sheet on HR 1122 stated that "Intact D&X is not an accepted 'medical practice'. . . . the Board's expert scientific report recommends against its use."[35]

While ACOG has consistently opposed legal prohibition of intact D&X/partial birth abortion, and the AMA has taken varying positions regarding such legislation, neither organization has yet offered any specific circumstances in which the procedure is believed to be medically necessary. ACOG's statement that there "may" be such circumstances is clearly just another way of expressing generalized opposition to legislative regulation of physicians. Indeed, when interviewed by American Medical News about this statement, ACOG President Fredric D. Frigoletto, Jr., "maintained that the [ACOG Executive] Board did not 'endorse' the procedure. 'There are no data to say that one of the procedures is safer than the other,' he said. When asked why the statement said the procedure 'may be the best' in some cases, Dr. Frigoletto

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[34] American Medical Association, *AMA Press Releases: AMA Supports H.R. 1122 As Amended, Statement by Nancy W. Dickey, MD, Chair of the AMA Board of Trustees* (reproduced at App. 5-6 for the convenience of the Court).

[35] American Medical Association, *AMA Board of Trustees FACT SHEET on HR 1112* (June 1997) (reproduced at App. 1-4 for the convenience of the Court).

answered, 'or it may not be.' "[36] Such reference to the bare possibility of health risks by a professional organization opposed in principle to legislative regulation of abortion cannot constitute an "undue burden," if the undue burden test is to play its role of distinguishing between permissible and impermissible governmental regulation.

The district court below acknowledged as correct the statement of its most favored expert, Dr. Stubblefield,[37] that there are no medical studies "which compare the safety of the intact D&X to other abortion procedures or conclude that the D&X is safer than other abortion procedures."[38] Two published articles in The Journal of the American Medical Association relating to the D&X procedure have also noted the lack of credible studies on safety.[39]

The district court, not fearing to tread beyond the confines of published studies and the expert panels of ACOG and the AMA, dismissed the lack of published studies as unimportant.[40] The district court relied largely upon Dr. Stubblefield, "a teacher and user of the D&E

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[36] Diane M. Gianelli, *Medicine adds to debate on late-term abortions: ACOG draws fire for saying procedure 'may' be best option for some*, 40 Amer. Med. News 1 (March 3, 1997) (reproduced at App. 21-27 for the convenience of the Court).

[37] *See* 11 F. Supp. 2d at 1116 (Dr. Stubblefield most persuasive and helpful expert).

[38] 11 F. Supp. 2d at 1112.

[39] *See* Janet E. Gans Epner, *et al., Late-term Abortion*, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26 1998) ("[i]n the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown"); M. LeRoy Sprang & Mark G. Neerhof, *Rationale for Banning Abortions Late in Pregnancy*, 280 J. Amer. Med. Ass'n 744 (Aug. 26, 1998) ("no credible studies on intact D&X that evaluate or attest to its safety").

[40] *See, e.g.*, 11 F. Supp. 2d at 1124.

procedure,"[41] to buttress claims that the D&X procedure was medically superior to D&E abortion, despite the fact that Dr. Stubblefield "has not performed this procedure himself, nor has he viewed anyone else perform it."[42] The court never appears to have wondered why Dr. Stubblefield, its favored expert, had never used or taught the intact D&X procedure if he believed it to be superior to D&E. Nor was the district court deterred by Dr. Stubblefield's testimony that characterized the possible health benefits of D&X as mere theory which should be regarded as uncertain pending data.[43] Similarly, Respondent's other expert, Dr. Hodgson, who had "performed or supervised at least 30,000 abortions,"[44] and yet had never intentionally performed an intact D&X,[45] was relied upon to buttress claims of D&X as a "technological advance."[46] Such appearance of a "courtroom conversion" by Respondent's experts, who adhere to the D&E in their medical practice while opining about the supposed superiority of the D&X inside the courtroom, undermines any support for the findings of the district court.

The district court's speculations on why D&X is superior to D&E failed to mention or take account of the special risks that may be associated with D&X. First, "some physicians have suggested that the procedure may increase complications, such as cervical incompetence."[47] The threat of cervical incompetence is related to the

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[41] 11 F. Supp. 2d at 1125 n.35.

[42] 11 F. Supp. 2d at 1112.

[43] *See* 11 F. Supp. 2d at 1111 ("theoretically, would be safer. It would be a while before we have the data to compare. . . . ")

[44] 11 F. Supp. 2d at 1105.

[45] *See* 11 F.2d at 1105, 972 F. Supp. at 516.

[46] *See* 972 F. Supp. at 516.

[47] 280 J. Amer. Med. Ass'n at 726 (footnote omitted).

amount of cervical dilation.[48] Cervical incompetence consequent to intact D&X may make it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term.

Further risks peculiar to intact D&X are described as follows:

> First, the risk of uterine rupture may be increased. An integral part of the D&X procedure is an internal podalic version, during which the physician instrumentally reaches into the uterus, grasps the fetus' feet, and pulls the feet down into the cervix, thus converting the lie to a footling breech. The internal version carries risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus. According to *Williams Obstetrics*, "there are very few, if any, indications for internal podalic version other than for delivery of a second twin."[49]

The risk of podalic version (repositioning the fetus) referred to in *Williams Obstetrics* involves manual internal version (repositioning by hand within the woman's body) to deliver a fetus in the third trimester. While this differs somewhat from version (repositioning) of the fetus with an instrument as described by Haskell in the D&X procedure, the risks of Haskell's procedure are unknown, and can only be the subject of speculation based upon the risks of similar, but not identical procedures.

> The second potential complication of intact D&X is the risk of iatrogenic laceration and secondary hemorrhage. Following internal version and partial breech extraction, scissors are forced into the base of the fetal skull while it is lodged in the birth canal. This blind procedure risks maternal injury from laceration of the uterus or

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[48] A. Golan, *et al.*, *Incompetence of the Uterine Cervix*, 44 Obstet. Gynecol. Surv. 96-107 (1989).

[49] 280 J. Amer. Med. Ass'n at 744-45 (footnote omitted).

> cervix by the scissors and could result in severe bleeding and the threat of shock or even maternal death.[50]

All of these risks, if realized, have significant import for maternal health.

The district court's failure to take account of the negative risks associated with D&X in its supposed findings on the comparative superiority of intact D&X, alone renders those findings clearly erroneous. Any comparative analysis of the various techniques applicable to a specific stage of pregnancy or circumstance must obviously take account of the relative risks of *both* procedures to be valid. Simply listing the risks associated with second trimester D&E abortion, as the court did,[51] fails utterly to constitute findings of fact on the *comparative* risks of D&E and D&X.

Amici believe that the nearly eight years that have passed since Dr. Haskell's 1992 paper on intact D&X have demonstrated that the procedure is never medically necessary, and remains generally inferior, in terms of maternal health, to existing abortion methods. Although abortion rights orientated experts are clearly willing to go into federal court and testify as to the efficacy of the D&X, physicians have retained their preference, in actual practice, for various forms of D&E and induction methods.[52] Professional organizations with strong interests in professional autonomy and maternal health have been unable to identify any particular circumstances where there is a need for the procedure. While the AMA

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[50] *Id.* (footnotes omitted).

[51] *See* 11 F. Supp. 2d at 1123.

[52] *See, e.g.*, David A. Grimes, *The Continuing Need for Late Abortions*, 280 J. Amer. Med. Ass'n 747, 748 (Aug. 26, 1998) ("only a small number of physicians nationwide" perform intact dilation and extraction).

no longer supports the federal ban on partial-birth abortion due to its overall opposition to criminal sanctions against physicians, the AMA continues to oppose this procedure.[53] Rather than being a new method on the rise, D&X remains after almost eight years an aberrant curiosity, a medically needless flashpoint of deeply-felt division.

The weakness of the record in the instant case contrasts strangely with the supposed findings of the district court. None of the experts in the instant case had ever performed a D&X procedure. Even Respondent Carhart performed the D&X procedure in only about ten percent of his post-fifteen week abortions. Moreover, Carhart did not identify particular circumstances that necessitated use of D&X, but instead chose the procedure based on the happenstance of the presentation of the fetus, failing even in transverse presentations to make sustained efforts to effect a D&X procedure. The actions of the Respondent and his experts undercut any claims or finding of medical necessity for this procedure.

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[53] An October 21, 1999 "Statement For Response Only" issued by the AMA states:

> U.S. Senator . . . Santorum . . . has reintroduced a bill that would ban intact dilation and extraction. The American Medical Association (AMA) has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure.
>
> The AMA has asked Sen. Santorum to remove the criminal sanctions from his bill, but such a change has not been made. For this reason we do not support the bill.

American Medical Association, *Statement for Response Only* (Oct. 21, 1999) (reproduced at App. 10 for the convenience of the Court).

C. THERE ARE NO SPECIAL MEDICAL OR HEALTH INDICATIONS FOR D&X

The district court's over-reaching, clearly erroneous "finding" that the D&X procedure is generally superior to the more common and generally accepted methods, in combination with the fact that Respondent Carhart chose D&X based on the happenstance of fetal position, rather than special maternal indications, makes this case a particularly poor candidate for exploring whether there may be rare cases where D&X is necessary to maternal health. Neither the district court nor the appellate court below relied to a significant degree on such a claimed need for D&X in specialized or extreme medical circumstances. Nonetheless, *amici*, having extensive experience with a wide variety of difficult medical circumstances related to maternal-fetal health, wish to emphasize that speculations on a supposed need for the D&X procedure in particular circumstances are groundless. This fact is not changed by the invocation of the emotionally charged circumstances surrounding tragic fetal abnormalities.

1. INTACT D&X ABORTION IS NOT INDICATED FOR HYDROCEPHALUS

Hydrocephalus, or excessive fluid accumulated in the fetal head, has sometimes been offered as a condition necessitating intact D&X, due to the impossibility of normally delivering the enlarged head. Of course, as ACOG and the AMA have noted, D&X has never been identified as the standard of care or indicated treatment for any particular circumstances. In fact, the usual treatment for hydrocephalus is transabdominal cephalocentesis, whereby the excess fluid in the fetal skull is drained through the use of a thin needle placed inside the womb through the woman's abdomen.[54] By contrast, proceeding transvaginally with scissors – the very crude method

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[54] *See, e.g.*, 280 J. Amer. Med. Ass'n at 745.

adopted by Haskell – or even a needle places the woman at an increased risk of infection because of the non-sterile vaginal environment.

2. INTACT D&X IS NOT INDICATED OR NECESSARY IN ORDER TO DIAGNOSE FETAL ABNORMALITIES

It has sometimes been stated that it is useful to have an intact fetus in order to confirm abnormal prenatal diagnoses.[55] However, "a study involving 60 patients who underwent D&E at 14 to 22 weeks of gestation after fetal abnormalities were detected found that D&E successfully and consistently confirmed abnormal prenatal diagnoses."[56] Notwithstanding the results of these studies, to the extent that intact fetal salvage is desirable, this can be achieved through labor induction abortion.[57] Again, intact D&X upon examination has failed to become the standard of care *for any particular circumstance*, as there are always medically-sound alternatives.

III. INTACT D&X CONFUSES THE DISPARATE ROLES OF A PHYSICIAN IN CHILDBIRTH AND ABORTION IN A WAY THAT BLURS THE LINE BETWEEN INFANTICIDE AND ABORTION AND

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[55] *See* W. Martin Haskell, *et al., Surgical Abortion After the First Trimester* in *A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.* eds., 1999) at 136.

[56] 280 J. Amer. Med. Ass'n at 727 (footnote number omitted) (citing L.P. Shulman, *et al., Dilation and evacuation for second-trimester genetic pregnancy termination*, 75 Obstet. Gynecol. 1037-40 (1990); *see also* W. Hern, *et al., Outpatient abortion for fetal anomaly and fetal death from 15-34 menstrual weeks' gestation: Techniques and clinical management* 81 Obstet Gynecol 301-06 (1993)).

[57] W. Martin Haskell, *et al., Surgical Abortion After the First Trimester in A Clinician's Guide to Medical and Surgical Abortion* (Maureen Paul, *et al.* eds., 1999) at 125.

UNDERMINES THE PUBLIC INTEGRITY OF THE MEDICAL PROFESSION

Even abortion rights proponents have frequently expressed a particularly negative reaction to intact D&X, otherwise known as partial-birth abortion. This negative reaction is frequently shared by medical providers who are well acquainted with the relative gruesomeness of surgery and particular methods of abortion. There is something particularly shocking and aberrant about this particular procedure beyond, or different from, the difficult issues raised by abortion itself.

Intact D&X is aberrant and troubling because the technique confuses the disparate roles of a physician in childbirth and abortion in such a way as to blur the medical, legal, and ethical line between infanticide and abortion. When the physician performs (as necessary) instrumental version of the live fetus to a footling breech – using terminology (footling breech) and techniques borrowed from past and current obstetrics – she appears initially to be assisting live delivery. As the physician manually performs breech extraction of the body of a live fetus, excepting the head, she continues in the apparent role of an obstetrician delivering a child. At this point of the procedure it is possible for all of the fetus' body, except for the head, to be outside of the woman's body, and the physician is holding the fetus' live body in one of her hands. The techniques used to this point of the procedure appear to be clear adaptations of the role of a physician acting with a duty of care to both fetus and woman, and the fetus is remarkably close – whether viable or not – to achieving live delivery.

Suddenly, the physician appears to switch roles and performs an act quite contrary to the obstetrical role: stabbing the base of the skull of the living fetus with a pair of scissors, spreading the scissors to enlarge the opening, inserting a suction catheter, and evacuating the skull contents. The physician acts directly against the physical life of a fetus who she has previously delivered, all but the head, out of the uterus. Even when the method

is altered somewhat to involve other means of "evacuating" or "decompressing" the fetal skull, this portion of the intact D&X dramatically shifts the technique and role of the physician from delivery of a live fetus out of the womb to destroyer of a fetus almost entirely outside the uterus.

Even abortion rights proponents recognize that post-fifteen-week abortions are difficult and troubling for all involved.[58] However, the reason that Congress and thirty state legislatures have, usually by wide margins, passed bans on intact D&X abortion amounts to more than a negative response to second and third trimester abortion, and more than discomfort with the raw gruesomeness of surgery or late-term abortion. Rather, in a society that, due to this Court's precedents, must permit elective pre-viability abortion and health-indicated post-viability abortion, there is a medical, legal, and ethical imperative to draw a bright, unblurred line between infanticide and abortion. Intact D&X threatens this bright line between infanticide and abortion in a way that undermines both the public integrity of the medical profession and society's interest in protecting human life.

IV. NEBRASKA'S USE OF THE TERM "PARTIAL-BIRTH ABORTION" AND ACCOMPANYING DEFINITIONS FAIRLY DISTINGUISH INTACT D&X FROM STANDARD D&E ABORTION WHILE EXPRESSING THE STATE INTEREST IN DRAWING A BRIGHT LINE BETWEEN INFANTICIDE AND ABORTION

Even today, there is no fixed medical term for the procedure at issue herein. While ACOG and the AMA appear generally to use the term "intact dilation and extraction," as late as August 1998 the well-known

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[58] David A. Grimes and Willard Cates, Jr., *"Dilation & Evacuation"* in *Second Trimester Abortion: Perspectives After a Decade of Experience* (Gary S. Berger, *et al.* eds., 1981) at p. 130.

reproductive health expert David A. Grimes used the term "intact D&E."[59] The district court below seemed somewhat challenged by the medical terminology, referring to the procedure alternatively as "intact dilation and evacuation," "intact D&X," "intact D&E," and "intact dilation and extraction."[60] Yet it also used one of these terms (intact D&E) for a different procedure in which the fetus is entirely within the uterus – and in one instance already dead – when the fetal skull size is reduced.[61] Moreover, despite claims that the term "intact dilation and extraction" is a medical term, the district court referred to this term as emanating from "the popular press."[62]

Under these circumstances, the Nebraska legislature, acting in 1997, cannot be fairly criticized for failing to use a medical term, as medical terminology has been evolving and uncertain. Moreover, the medical terminology fails to express the state's interests in drawing a clear line between infanticide and abortion which safeguards the public integrity of the medical profession. The term "partial-birth abortion" expresses reasonably well the gravamen of the objection to this procedure, which is that the procedure confuses the role of physician in childbirth and physician in abortion, blurs the line between infanticide and abortion, and undermines the public integrity of the medical profession. "The 'partial birth abortion' legislation is by its very name aimed exclusively at the procedure by which a 'living fetus' is 'intentionally and

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[59] David A. Grimes, *The Continuing Need for Late Abortions*, 280 J. Amer. Med. Ass'n 747, 748 (Aug. 26, 1998).

[60] *See, e.g.*, 11 F. Supp. 2d at 1105.

[61] *See* 11 F. Supp. 2d at 1111-12.

[62] 11 F. Supp. 2d at 1105.

deliberately' given 'partial birth' and 'delivered' for 'for the purpose of' killing it."[63]

In their statutory construction the courts below have failed to interpret the statute in accord with its clearly expressed purpose. It is perverse to focus exclusively on the term "substantial portion," apart from the purposes of the act and important statutory terms such as "partial-birth abortion," "delivers," "delivers vaginally a living unborn child before killing the unborn child." Properly interpreting the various terms of the statute in light of the statute's purpose, the definition of partial-birth abortion clearly excludes the dismemberment of the fetus as is common with D&E abortion. There is certainly nothing resembling a "partial birth" in classic Dilation and Evacuation (D&E) abortion, nor does a D&E resemble intentional "delivery" of a living fetus into the birth canal.

CONCLUSION

For the foregoing reasons, we respectfully request that this Court reverse the judgments of the district court and Court of Appeals.

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[63] American Medical Association, *AMA Board of Trustees FACT SHEET on HR 1122* (June 1997) (reproduced at App. 1-4 for the convenience of the Court).

American Medical Association
Physicians dedicated to the health of America

[LOGO]

AMA Board of Trustees FACT SHEET on HR 1122

1. Why did AMA support HR 1122?

AMA supported HR 1122 because, in the Board's view, "partial birth abortion" or intact D&X is ethically wrong, and it could not otherwise be restricted. Leaders of the profession, like former Surgeon General C. Everett Koop and medical ethicist Edmund Pellegrino oppose use of the procedure, as do most physicians and most members of the public.

In addition, AMA's expert panel, which included an ACOG representative, could not find "any" identified circumstance where it was "the only appropriate alternative."

Finally, by giving its support in exchange for changes in the legislation, AMA was able to substantially improve the Federal law and the law in the many states which are using, and passing, the Federal model.

2. Why is Intact D&X ethically wrong? How is it different from other destructive abortion procedures?

The procedure is ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed *outside* of the womb. The "partial birth" gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body.

3. Does the Board endorse criminalization of "medical practice" by supporting HR 1122?

In the Board's view, Intact D&X is not an accepted "medical practice," so the answer is no. There is no consensus among obstetricians about its use, and the Board's expert scientific report recommends against its use. It has never been subject to even a minimal amount of the normal medical practice development. It is not in the medical text books.

The AMA policy opposing the criminalization of medical practice is aimed primarily at preventing the prosecution (as recently occurred in New York) of physicians who have made serious, unintentional errors. In contrast, society has a long tradition of legislating, and criminalizing, certain abortion procedures, e.g., elective third trimester abortions. The profession has, in general, *not* opposed those efforts and the profession has supported criminal restrictions on improper "medical" procedures, such as female genital mutilation.

4. What changes were made in HR 1122?

The amendments obtained by the AMA were substantial and they were the maximum changes that could be obtained. *Without* the changes:

> (a) a physician doing an Intact D&X because he or she believes there may be a risk to the mother's life would have to show that *"no other procedure would [have] suffice[d]"* to protect the mother, a difficult burden under any circumstance. The AMA changes entirely *deleted* the "no other procedure would suffice" requirement. When a woman is endangered by her pregnancy, her physician *retains the discretion* to choose this procedure over other procedures that might also be available.

> (b) a physician would *not* have had the right to halt any prosecution in order to obtain review by an *independent medical practice board* of the appropriateness of the physician's conduct. That right is now guaranteed by AMA's changes.
>
> (c) a physician *intending to do a delivery* who encountered emergency circumstances that in his or her judgment required use of the procedure would have been subject to the law. He or she now has *complete discretion* to do whatever is necessary for the life *or* health of the woman without any concern for the statute. It does not apply.
>
> (d) a physician doing certain *other* kinds of abortion procedures might have been concerned about the legislation. It is clear beyond question as a result of AMA's changes that the legislation covers *only* Intact D&X.

5. Can the legislation be read as covering other abortion techniques?

The "partial birth abortion" legislation is by its very name aimed exclusively at a procedure by which a "living fetus" is "intentionally and deliberately" given "partial birth" and "delivered" "for the purpose of" killing it. There is no other abortion procedure which could be confused with that description.

Throughout the debate over the bill in Congress, and in the press, *only* the procedure known as Intact D&X was described as being covered by the bill. Any extension of the bill would be patently unconstitutional. Notwithstanding ACOG's objection to the use of non "medical"

terms, ACOG has conceded that the sponsors' intent is clear and limited: "However, based on legislative testimony, ACOG believes the intent of the Federal ban is to criminalize *an* abortion technique . . . which *some* practitioners have termed Intact Dilation and Extraction (Intact D&X)." ACOG Factsheeet, April 14, 1997 (emphasis added).

June 1997

Advocacy & Communications:

AMA Supports H.R. 1122 As Amended

"Partial-Birth Abortion Ban Act of 1997"

(Washington – May 20) – Nancy W. Dickey, MD, Chair of the AMA Board of Trustees issued the following statement:

> The American Medical Association Board of Trustees has determined to support H.R. 1122 because it has now been significantly changed to substantially meet the criteria which the Board established for any abortion legislation.
>
> Consistent with an expert report requested by AMA's House of Delegates last December and also forwarded to the AMA House last week for consideration at its June meeting, H.R. 1122 now narrowly defines the procedure to be restricted – a procedure for which AMA's expert panel could not find "any identified situation" in which it was "the only appropriate procedure to induce abortion" – and it broadens the exceptions.
>
> The changed language in the bill now: (a) makes it clear beyond any question that the accepted abortion procedure known as dilation and evacuation (also referred to as "D&E") is not covered by the bill, (b) permits the procedure to save the life of the mother without any obligation to show that "no other procedure would suffice," and (c) does not restrict use of the procedure for physicians intending a delivery at the outset, i.e., it can be done as necessary in their best medical judgment.

In addition, as also required by our legislative criteria letter, a physician will be entitled to stay any criminal proceeding in order to obtain expert review by the state medical board of any questioned conduct under the bill for use at trial.

As amended, H.R. 1122 is now a bill which impacts only a particular and broadly disfavored – both by experts and the public – abortion procedure. It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development. The bill has no impact on a woman's right to choose an abortion consistent with Roe v. Wade. Indeed, the procedure differs materially from other abortion procedures which remain fully available in part because it involves the partially delivered body of the fetus which is outside of the womb.

H.R. 1122 is serving as a model for many state legislatures and it is vitally important that the improvements which have been made become a part of the broader legislative process.

Advocacy & Communications

Letter to *The New York Times*
regarding AMA support of H.R. 1122

"Partial-Birth Abortion Ban Act of 1997"

The following letter from AMA Executive Vice President P. John Seward, MD was sent to *The New York Times:*

May 30, 1997

Letters to the Editor
The New York Times
229 W. 43rd Street
New York, NY 10036
Via Fax: 212-556-3622

Dear Editor:

There is no civility and very little truth in abortion politics. At the extreme ends of both sides – like the Frank Rich column about the AMA (Op. Ed. May 29, 1997) – there is only hysterical distortion designed to distract from the real issue.

The issue is not the AMA – which has been described by David Kessler as a "hero" of the anti-tobacco movement and whose Medicare policy was recently applauded in an editorial by this newspaper. The issue is whether the partial delivery of a living fetus for the purpose of killing it outside of the womb ought to be severely restricted. We believe, as a matter of ethical principle, it should rarely if ever be done. And although we also believe physicians should have broad discretion in medical matters, both this procedure and assisted suicide (as

well as female genital mutilation and lobotomies) can and should be regulated if the profession won't do it. And since there are safe, and indeed safer, abortion alternatives, we supported the Santorum bill as amended.

AMA's congressional advocacy is derived exclusively from the profession's values, especially the patient-physician relationship. But we cannot control the timing of the Congressional agenda. Our letters on abortion and Medicare – both public documents – went the same day because the Santorum bill ultimately came up the day that Congress had asked everyone – doctors, hospitals, home health care providers, insurance companies – to deliver their views on Medicare legislation. The Medicare letter went to 125 Congressional leaders, including Democratic leaders. It is similar to dozens of letters received on or about that same day from the other interested groups. Frank Rich could not be more wrong.

If it is just the Republicans we are trying to persuade we certainly would not have (a) delivered one day later a letter to Senator Kennedy supporting his efforts to expand access to care for children through an increased tobacco tax that the Republican leadership vigorously opposed, (b) stood one month earlier on the steps of the Capitol with Henry Waxman, demanding that Congress enact a lengthy anti-tobacco agenda, or (c) delivered on May 21 a letter to Representatives Kildee and Stark supporting ERISA reform which the Republicans

generally oppose, or engaged in countless other activities that defy partisan identification.

Sincerely,

P. John Seward, MD

App. 10

American Medical Association
Physicians dedicated to the health of America

[LOGO]

Statement

For Response Only **October 21, 1999**

"U.S. Senator Rick Santorum (R-PA) has reintroduced a bill that would ban intact dilation and extraction. The American Medical Association (AMA) has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure.

"The AMA has asked Sen. Santorum to remove the criminal sanctions from his bill, but such a change has not been made. For this reason we do not support the bill."

App. 11

American Medical

NEWS

AMERICAN MEDICAL ASSOCIATION
NOVEMBER 20, 1995
VOLUME 38 – NUMBER 43

Outlawing abortion method

Veto-proof majority in House votes to prohibit late-term procedure

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON – His strategy was simple: Find an abortion procedure that almost anyone would describe as "gruesome," and force the opposition to defend it.

When Rep. Charles T. Canady (R. Fla.) learned about "partial birth" abortions, he was set.

He and other anti-abortion lawmakers launched a congressional campaign to outlaw the procedure.

Following a contentious and emotional debate, the bill passed by an overwhelming – and veto-proof – margin: 288-139. It marks the first time the House of Representatives has voted to forbid a method of abortion. And although the November elections yielded a "pro-life" infusion in both the House and the Senate, massive cross-over voting occurred with a significant number of "pro-choice" representatives voting to pass the measure.

The controversial procedure, done in second and third-trimester pregnancies, involves an abortion in which the provider, according to the bill, "partially

vaginally delivers a living fetus before killing the fetus and completing the delivery."

"Partial birth" abortions, also called "intact D&E" (for dilation and evacuation), or "D&X" (dilation and extraction) are done by only a handful of U.S. physicians, including Martin Haskell, MD, of Dayton, Ohio, and, until his recent death, James T. McMahon, MD, of the Los Angeles area. Dr. McMahon said in a 1993 *AMNews* interview that he had trained about a half-dozen physicians to do the procedure.

The procedure usually involves the extraction of an intact fetus, feet first, through the birth canal, with all but the head delivered. The surgeon forces scissors into the base of the skull, spreads them to enlarge the opening, and uses suction to remove the brain.

The procedure gained notoriety two years ago, when abortion opponents started running newspaper ads that described and illustrated the method. Their goal was to defeat an abortion rights bill then before Congress on grounds it was so extreme that states would have no ability to restrict even late-term abortions on viable fetuses. The bill went nowhere but strong reaction to the campaign prompted anti-abortion activists to use it again.

They drafted a bill that would ban the procedure, after considering a number of other options. An Ohio law passed earlier this year, for instance, bans "brain suction" abortions, except when all other methods would pose a greater risk to the pregnant woman. It has been enjoined pending a challenge.

Mixed feelings in medicine

The procedure is controversial in the medical community. On the one hand, organized medicine bristles at the notion of Congress attempting to ban or regulate any procedures or practices. On the other hand, even some in the abortion provider community find the procedure difficult to defend.

"I have very serious reservations about this procedure," said Colorado physician Warren Hern, MD. The author of *Abortion Practice*, the nation's most widely used textbook on abortion standards and procedures. Dr. Hern specializes in late-term procedures.

He opposes the bill, he said, because he thinks Congress has no business dabbling in the practice of medicine and because he thinks this signifies just the beginning of a series of legislative attempts to chip away at abortion rights. But of the procedure in question he says, "You really can't defend it. I'm not going to tell somebody else that they should not do this procedure. But I'm not going to do it."

Dr. Hern's concerns center on claims that the procedure in late-term pregnancy can be safest for the pregnant women, and that without this procedure women would have died. "I would dispute any statement that this is the safest procedure to use," he said.

Turning the fetus to a breech position is "potentially dangerous," he added. "You have to be concerned abut causing amniotic fluid embolism or placental abruption if you do that."

Pamela Smith, MD, director of medical education, Dept. of Ob-Gyn at Mt. Sinai Hospital in Chicago, added two more concerns: cervical incompetence in subsequent pregnancies caused by three days of forceful dilation of the cervix and uterine rupture caused by rotating the fetus within the womb.

"There are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life of the mother," Dr. Smith wrote in a letter to Canady.

Partial-Birth Abortion Ban Act of 1995

The bill: HR 1833

Summary: Bans abortions in which provider 'partially vaginally delivers a living fetus before killing the fetus and completing the delivery.'

Exceptions: 'Life of mother' and physician belief that no other procedure would suffice as "affirmative defense" to prosecution or civil action.

Penalties: Possibility of suits, fines and/or imprisonment of up to two years.

Proponents: Procedure is medically and morally indefensible.

Opposition: Congress has no business legislating medical standards and procedures; bill begins erosion *of* abortion rights.

Abortion

The procedure also has its defenders. The procedure is a "well-recognized and safe technique by those who provide abortion care," Lewis H. Koplik, MD, an Albuquerque, N.M., abortion provider, said in a statement that appeared in the *Congressional Record*.

"The risk of severe cervical laceration and the possibility of damage to the uterine artery by a sharp fragment of calvarium is virtually eliminated. Without the release of thromboplastic material from the fetal central nervous system into the maternal circulation, the risk of coagulation problems, DIC [disseminated intravascular coagulation], does not occur. In skilled hands, uterine perforation is almost unknown," Dr. Koplik said.

Bruce Ferguson, MD, another Albuquerque abortion provider, said in a letter released to Congress that the ban could impact physicians performing late-term abortions by other techniques. He noted that there were "many abortions in which a portion of the fetus may pass into the vaginal canal and there is no clarification of what is meant by 'a living fetus.' Does the doctor have to do some kind of electrocardiogram and brain wave test to be able to prove their fetus was not living before he allows a foot or hand to pass through the cervix?"

Apart from medical and legal concerns, the bill's focus on late-term abortion also raises troubling ethical issues. In fact, the whole strategy, according to Rep. Chris Smith (R. N.J.), is to force citizens and elected officials to move beyond a philosophical discussion of "a woman's

right to choose," and focus on the reality of abortion. And, he said, to expose those who support "abortion on demand" as "the real extremists."

Another point of contention is the reason the procedure is performed. During the Nov. 1 debate before the House, opponents of the bill repeatedly stated that the procedure was used only to save the life of the mother or when the fetus had serious anomalies.

Rep. Vic Fazio (D. Calif.) said, "Despite the other side's spin doctors – real doctors know that the late-term abortions this bill seeks to ban are rare and they're done only when there is no better alternative to save the woman, and, if possible, preserve her ability to have children."

Dr. Hern said he could not imagine a circumstance in which this procedure would be safest. He did acknowledge that some doctors use skull-decompression techniques, but he added that in those cases fetal death has been induced and the fetus would not purposely be rotated into a breech position.

Even some physicians who specialize in this procedure do not claim the majority are performed to save the life of the pregnant woman.

In his 1993 interview with *AMNews*, Dr. Haskell conceded that 80% of his late-term abortions were elective. Dr. McMahon said he would not do an elective abortion after 26 weeks. But in a chart he released to the House Judiciary Committee, "depression" was listed most often as the reason for late-term nonelective abortions with

maternal indications. "Cleft lip" was listed nine times under fetal indications.

The accuracy of the article was challenged, two years after publication, by Dr. Haskell and the National Abortion Federation, who told Congress the doctors were quoted "out of context," *AMNews* Editor Barbara Bolsen defended the article, saying *AMNews* "had full documentation of the interviews, including tape recordings and transcripts."

Bolsen gave the committee a transcript of the contested quotes, including the following, in which Dr. Haskell was asked if the fetus was dead before the end of the procedure.

"No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress – intrauterine stress during, you know, the two days that the cervix is being dilated. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken.

"So in my case, I would say probably about a third of those are definitely are [sic] dead before I actually start to remove the fetus. And probably the other two-thirds are not," said Dr. Haskell.

In a letter to Congress before his death, Dr. McMahon stated that medications given to the mother induce "a medical coma" in the fetus, and "there is neurological fetal demise."

But Watson Bowes, MD, a maternal-fetal specialist at University of North Carolina, Chapel Hill, said in a letter

to Canady that Dr. McMahon's statement "suggests a lack of understanding of maternal-fetal pharmacology. . . . Having cared for pregnant women who for one reason or another required surgical procedures in the second trimester, I know they were often heavily sedated or anesthetized for the procedures, and the fetuses did not die."

Next move in the Senate

At *AMNews* press time, the Senate was scheduled to debate the bill. Opponents were lining up to tack on amendments, hoping to gut the measure or send it back to a committee where it could be watered down or rejected.

In a statement about the bill, President Clinton did not use the word "veto." But he said he "cannot support" a bill that did not provide an exception to protect the life and health of the mother. Senate opponents of the bill say they will focus on the fact that it does not provide such an exception.

The bill does provide an affirmative defense to a physician who provides this type of abortion if he or she reasonably believes the procedure was necessary to save the life of the mother and no other method would suffice.

But Rep. Patricia Schroeder (D. Colo.) says that's not sufficient. "This means that it is available to the doctor after the handcuffs have snapped around his or her wrists, bond has been posted, and the criminal trial is under way," she said during the House debate.

Canady disagrees. "No physician is going to be prosecuted and convicted under this law if he or she reasonably believes the procedure is necessary to save the life of the mother."

Organized medicine positions vary

The physician community is split on the bill. The California Medical Assn., which says it does not advocate elective abortions in later pregnancy, opposes it as "an unwarranted intrusion into the physician-patient relationship." The American College of Obstetricians and Gynecologists also opposes it on grounds it would "supersede the medical judgment of trained physicians and . . . would criminalize medical procedures that may be necessary to save the life of a woman," said spokeswoman Alice Kirkman.

The AMA has chosen to take no position on the bill, although its Council on Legislation unanimously recommended support. AMA Trustee Nancy W. Dickey, MD, noted that although the board considered seriously the council's recommendations, it ultimately decided to take no position, because it had concerns about some of the bill's language and about Congress legislating medical procedures.

Meanwhile, each side in the abortion debate is calling news conferences to announce how necessary or how ominous the bill is. Opponents highlight poignant stories of women who have elected to terminate wanted pregnancies because of major fetal anomalies.

Rep. Nita Lowey (D. N.Y.) told the story of Claudia Ames, a Santa Monica woman who said the procedure had saved her life and saved her family.

Ames told Lowey that six months into her pregnancy, she discovered the child suffered from severe anomalies that made its survival impossible and placed Ames' life at risk.

The bill's backers were "attempting to exploit one of the greatest tragedies any family can ever face by using graphic pictures and sensationalized language and distortions," Ames said.

Proponents focus on the procedure's cruelty. Frequently quoted is testimony of a nurse. Brenda Shafer, RN, who witnessed three of these procedures in Dr. Haskell's clinic and called it "the most horrifying experience of my life.

"The baby's body was moving. His little fingers were clasping together. He was kicking his feet." Afterwards, she said, "he threw the baby in a pan." She said she saw the baby move. "I still have nightmares about what I saw."

Dr. Hern says if the bill becomes law, he expects it to have "virtually no significance" clinically. But on a political level, "it is very, very significant."

"This bill's about politics," he said, "it's not about medicine."

American Medical

NEWS

AMERICAN MEDICAL ASSOCIATION •
MARCH 3, 1997
• VOLUME 48 • NUMBER 9

Medicine adds to debate on late-term abortion

ACOG draws fire for saying procedure 'may' be best option for some

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON – As Congress and state legislatures consider banning a procedure opponents call "partial birth" abortion, the medical community is conducting its own appraisal of this controversial late-term abortion procedure.

The American College of Obstetricians and Gynecologists weighed in with an opinion from its Executive Board in January, saying it could identify "no circumstances under which this procedure would be the only option to save the life of the mother or preserve the health of the woman."

It added, however, that the procedure, which ACOG called intact dilation and extraction (D&X) and others call intact dilation and evacuation (D&E), "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision."

Opinion comes under fire

ACOG was immediately taken to task by a group of physicians who oppose the procedure.

By endorsing a practice "for which no peer-reviewed or safety data exist," ACOG appears to be violating its own standards, said members of PHACT (Physicians Ad Hoc Coalition for Truth), a group of about 400 physicians, many of whom are also ACOG members.

This statement "clearly does not represent a consensus among the nation's obstetricians and gynecologists as to the safety or appropriateness, under any circumstances, of partial birth abortion," the PHACT letter said. It added that it found it "unusual that PHACT, a coalition of doctors formed for no other reason than to investigate medical claims made about partial-birth abortion, was not invited to participate in these deliberations."

ACOG President Fredric D. Frigoletto, MD, in an interview, maintained that the board did not "endorse" the procedure. "There are no data to say that one of the procedures is safer than the other," he said. When asked why the statement said the procedure "may be the best" in some cases, Dr. Frigoletto answered, "or it may not be."

William Stalter, MD, an Ohio ob-gyn, said he feels let down by his professional organization.

ACOG, he said, "is supposed to be our standard-bearer for high-quality care in obstetrics and gynecology. And it's supposed to be the watchdog [against] procedures that are poorly conceived or unproven. Yet here

they're defending a procedure that is virtually unstudied," said Dr. Stalter, a professor of obstetrics and gynecology at Wright State University in Dayton.

Dr. Frigoletto, in a letter responding to PHACT's complaints, said a task force drafted the policy statement that was amended and unanimously adopted by ACOG's executive board in January. "Clearly our organizations do not agree on the content of the statement," he wrote. "I hope we can respect these differences."

Meanwhile, the American Medical Association is also looking at the issue. Although it opted not to take a position when a federal bill to ban the procedure was considered last year, several members of the AMA House of Delegates pressed for a change in that position in the AMA's Interim Meeting in December. The house voted to have the AMA study the issue and evaluate the medical evidence before determining whether the practice conformed to the standards of good medical practice.

The AMA board discussed the issue at its February meeting, said AMA Trustee John C. Nelson, MD, a Salt Lake City ob-gyn. But it came to no conclusions.

"I'm not sure exactly what we'll say," he said. "If the medical literature or our colleagues cannot justify this procedure, we'll say we shouldn't do it. If in fact we can justify it, we'll say we could do it."

What medical groups have in common when viewing a potential ban on the procedure is a reluctance to allow Congress to meddle in medical matters. But this stance invites criticism from those who point out that many medical groups supported congressional efforts to pass

laws requiring insurers to cover minimum stays for childbirth deliveries and banning another controversial procedure called female circumcision or genital mutilation.

Looking for the science

The late-term abortion procedure is difficult to study, Dr. Nelson said, because there are no published reports on it. "We want to have the information so we can come up with a considered and reasoned viewpoint," Dr. Nelson said. He added that the AMA "will have a board report on the issue in June."

Without published data and peer-reviewed studies on the procedure, it's hard to reach clear findings about it. Now that Congress is taking a second look at a bill to ban the procedure and at least 25 states have introduced similar legislation, safety questions are once again being raised. The bill to ban it passed in both the Senate and the House last year, but it was vetoed by President Clinton.

Those who perform the procedure say it is safer for the woman and more convenient for the surgeon. Although the whole procedure takes three days, to allow for the women to come in for frequent laminaria insertions to dilate her cervix, the actual operation is scheduled on an outpatient basis and takes only five to 15 minutes.

Some providers say this method is safer than the classic D&E procedure in which the fetus is dismembered in the womb, leaving the mother at greater risk for internal perforations caused by either the slip of the surgeon's

instruments or bones from the fetus broken inside her body.

They claim that the intact D&E, because it avoids much of the sharp instrumentation and bone tears, is the procedure of choice for late-term abortions to preserve the woman's future fertility.

At a news conference this fall, the president spoke movingly of the women who chose this method to end their wanted pregnancies because of unexpected fetal anomalies. This procedure, he said, allowed them the chance to have another baby.

Opponents of the procedure assert, however, that the claim is without medical merit, and note that one of the five women at Clinton's veto ceremony had five miscarriages after her intact D&E. The procedure, opponents say, is potentially risky and actually contraindicated for fertility enhancement.

Late-term abortion options

A better option, they maintain, is to deliver the fetus by induction, using prostaglandin or pitocin to ripen the cervix and induce labor. Fetus demise can be induced beforehand.

Some also question the necessity of killing the fetus through brain suction or any other method if it has a condition incompatible with life and suggest it is "more humane" to have the physician induce labor and let the child die naturally.

Critics also say turning the fetus to a breech position can cause amniotic fluid embolism, placental abruption or uterine rupture.

And they maintain that the forcible dilation necessary to prepare the women's cervix for the procedure risks creating an "incompetent cervix," which could prevent a woman from carrying future pregnancies to term.

Diana Grossheim, from Huntington Beach, Calif., may be one of those women. Grossheim had an intact D&E in 1995. She now has an incompetent cervix.

When Grossheim's almost 21-week-old fetus died in utero, she said her physician told her she had two choices: labor, which was described as up to 48 hours of torture, or intact D&E, which her doctor described as "more merciful."

Grossheim said the procedure was "three days of pure hell" – both physical and mental.

She had to stay in a hotel and go back and forth to the clinic for laminaria changes. She was afraid she might deliver the baby in the hotel. On her second night, the pain was terrible – she was vomiting, cramping and screaming all night.

When her daughter was finally delivered, Grossheim said she and her husband didn't understand why she had such a flat head. If they were told about the brain suction procedure, it wasn't in terms she could understand, said the high school math teacher.

When Grossheim became pregnant again, she was told during a routine ultrasound in her 23rd week that she had an incompetent cervix and had to go on bed rest

for the remainder of her pregnancy. She delivered a healthy boy at 37 weeks, but still remembers the second half of her pregnancy as uncomfortable and frightening – thinking the baby would come any time and would die, too. She was heavily medicated and having contractions around the clock.

She's now 35 years old and would like to get pregnant again. But she can't afford to hire someone to watch her child while she spends her next pregnancy in bed. And she fears her chances of carrying to term are slim.

In retrospect, Grossheim wishes she had chosen the labor option. She would have felt safer in the hospital, where her pain could have been controlled and her fear of delivering alone eliminated. And she doesn't see any justification for the intact D&E procedure.

"Now that I've been through actual labor and delivery," she said, "I think it was much easier than what I went through."